

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

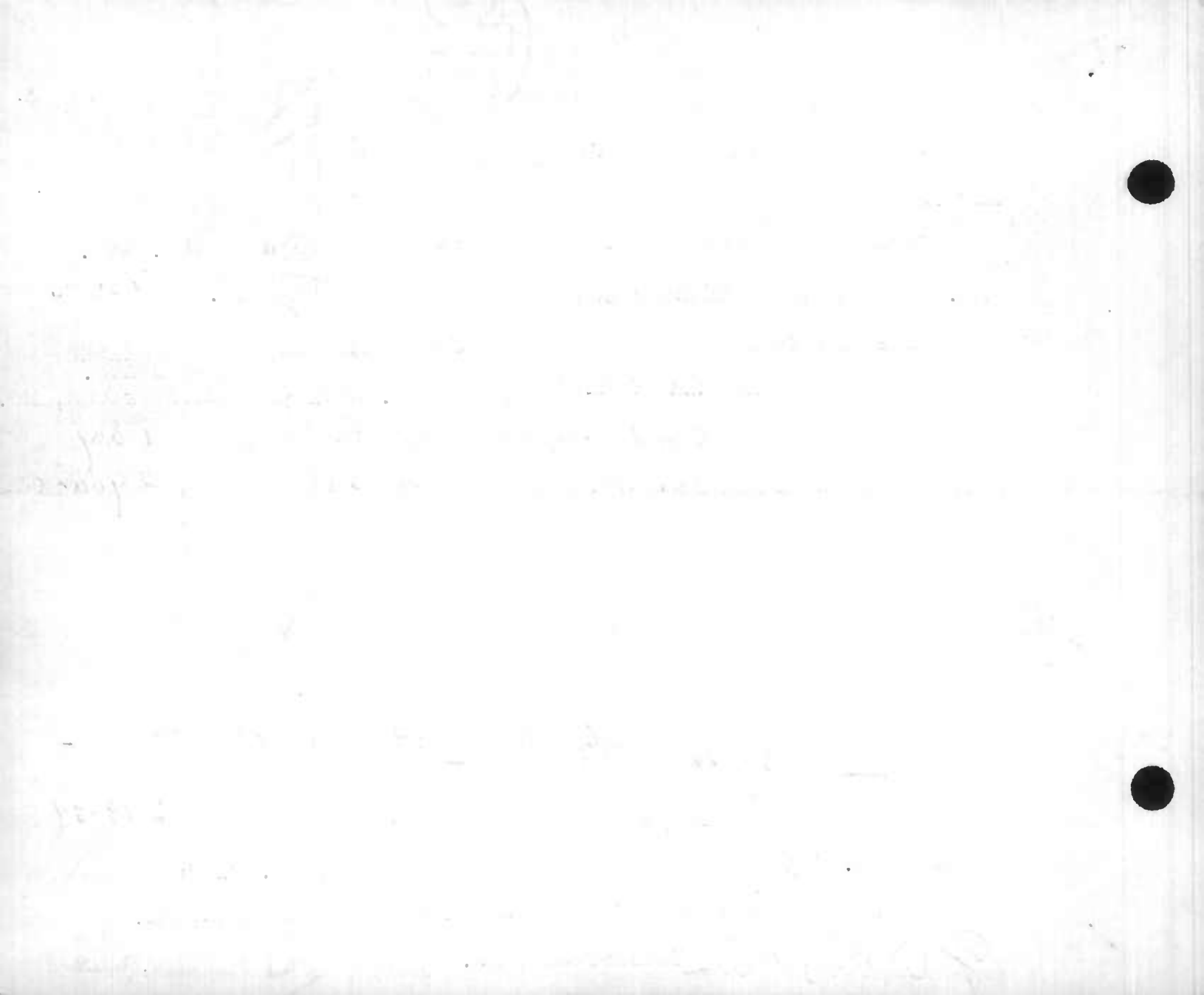
8416194

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillie May Angevine			2a. DATE OF DEATH MONTH DAY YEAR 6 17 84		2b. HOUR 10:40 A.		
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan 17, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stenographer		12b. KIND OF BUSINESS OR INDUSTRY Vet. Adm.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Solomon Truitt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Biggs		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213 212 50 2276	
17. INFORMANT ADDRESS Rebecca K. Bexley		18. CAMPUS AVE. Chestertown, Md.		19. STREET ADDRESS / ZIP CODE High St. 21620			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-4</u> , 19 <u>84</u> , to <u>6-17</u> , 19 <u>84</u> , that (I) () lost saw the deceased alive on <u>6-16</u> , 19 <u>84</u> , and that in (my) () opinion death occurred on the date and hour and from the causes stated above, (I) () (did not) view the body after death.							
22b. SIGNATURE Wayne D. Benjamin		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-18-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne D. Benjamin		22e. ADDRESS Chestertown, Md. 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/20/84		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.	
24. FUNERAL DIRECTOR NAME Willis Wells		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR JUN 21 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson Randall	

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DHMH - 17
(VR A15 ME (5))
15M7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST STIRLING M. BRINKMAN, SR.										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 6 4 1984										2b. HOUR M											
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3/26/22		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 62 YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6-4-84		2:20P		2b. HOUR M															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Kent				MD.															
10. CITY OR TOWN OF DEATH Chestertown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rtd/Administrator				12b. KIND OF BUSINESS OR INDUSTRY SchoolDist																			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Kent		13c. CITY OR TOWN Golts		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt#1, Box 337, Shorewood Ests.				21637																	
14. FATHER'S NAME FIRST MIDDLE LAST Phillip Brinkman						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth McCullough																									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II				16b. SOCIAL SECURITY NO. 221 10 0874				17. INFORMANT Rt#1, Box 337, Golts, Md. Nancy B. Brinkman (Wife)																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4275 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>History of chest pain</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6/4/84																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																															
ACTUAL SIGNATURE Robert W. Farr				M.D. <u>Deputy</u>				MEDICAL EXAMINER				DATE SIGNED 6/4/84																			
EXAMINER'S NAME (TYPE OR PRINT) ROBERT W. FARR				ADDRESS Chestertown Kent Co. Md.																											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/6/84				23c. NAME OF CEMETERY OR CREMATORY Red Clay Cr. Presby Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, N. C., Del.																			
24. FUNERAL DIRECTOR NAME Albert J. McCrery, VII				ADDRESS 3924 Concord Pk.				25a. DATE REC'D. BY REGISTRAR JUN 11 1984				25b. REGISTRAR'S SIGNATURE John Davidson-Randall																			

Handwritten text at the top of the page, possibly a header or title, including the words "Lecture" and "Notes".

Handwritten text in the middle section of the page, appearing to be a paragraph or a list of points.

Handwritten text at the bottom of the page, possibly a conclusion or a signature.



Vertical text on the right margin, possibly a date or a reference number, including the words "1902" and "101104".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) Catherine Jane Bullen					2a. DATE OF DEATH MONTH DAY YEAR 6-10-84			2b. HOUR P 6:55 M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 28, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital,				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inc. Seamstress		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Spencers Trailer Park 21620	
14. FATHER'S NAME FIRST MIDDLE LAST Howard Coleman, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 218-03-0217		17. INFORMANT ADDRESS Betty Crouch, Rock Hall, Md 21661			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> 0389 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Septic</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-10</u> 19 <u>84</u> , to <u>6-10</u> 19 <u>84</u> , that (I) <u>was</u> last saw the deceased alive on <u>6-10</u> 19 <u>84</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.									
22b. SIGNATURE L. D. Benjamin M.D. 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne D. Benjamin M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-14-84	
22d. ADDRESS Chestertown, Md 21620									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 06/13/84		23c. NAME OF CEMETERY OR CREMATORY Wesley Chpel Ceme.		23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall11 Kent MD		
24. FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Homes, P.A., Chester, MD						25a. DATE REC'D. BY REGISTRAR JUN 18 1984 REGISTRAR'S SIGNATURE <u>Jana Decker</u>			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 6 7 9 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) E/A LOUISE GOULDEN			2a. DATE OF DEATH MONTH DAY YEAR JUNE 11, 1984			2b. HOUR M	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR MAY 3, 1919		6. AGE (IN YEARS (LAST BIRTHDAY)) 64 YRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH KENT MD	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KENT QUEEN ANNE'S SHOP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR	
12b. KIND OF BUSINESS OR INDUSTRY VARIOUS		13a. STREET ADDRESS 506 Calvert St.		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. CITY OR TOWN Chestertown	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH BROADWAY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSIE O'NEIL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-26-9080	
17. INFORMANT NAME ADDRESS MRS. MARTIN ROSE 506 Calvert St. Chestertown MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 Myocardial Infarction IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Previous CVA - recurrent Cerebral infarctions							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 7/10/70 , 19 84 , to 10/11 , 19 84 , that (I) (we) last saw the deceased alive on 6/11 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE G. Gottfried Baumann		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. GOTTFRIED BAUMANN		22e. ADDRESS CHESTERTOWN, MD. 21620					
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 6/16/84		23c. NAME OF CEMETERY OR CREMATORY AARON CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE ROCK HALL KENT MD.	
24. FUNERAL DIRECTOR NAME ADDRESS Kenneth W. ... CHESTERTOWN, MD.		25a. DATE REC'D. BY REGISTRAR JUN 18 1984		25b. REGISTRAR'S SIGNATURE [Signature]			

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

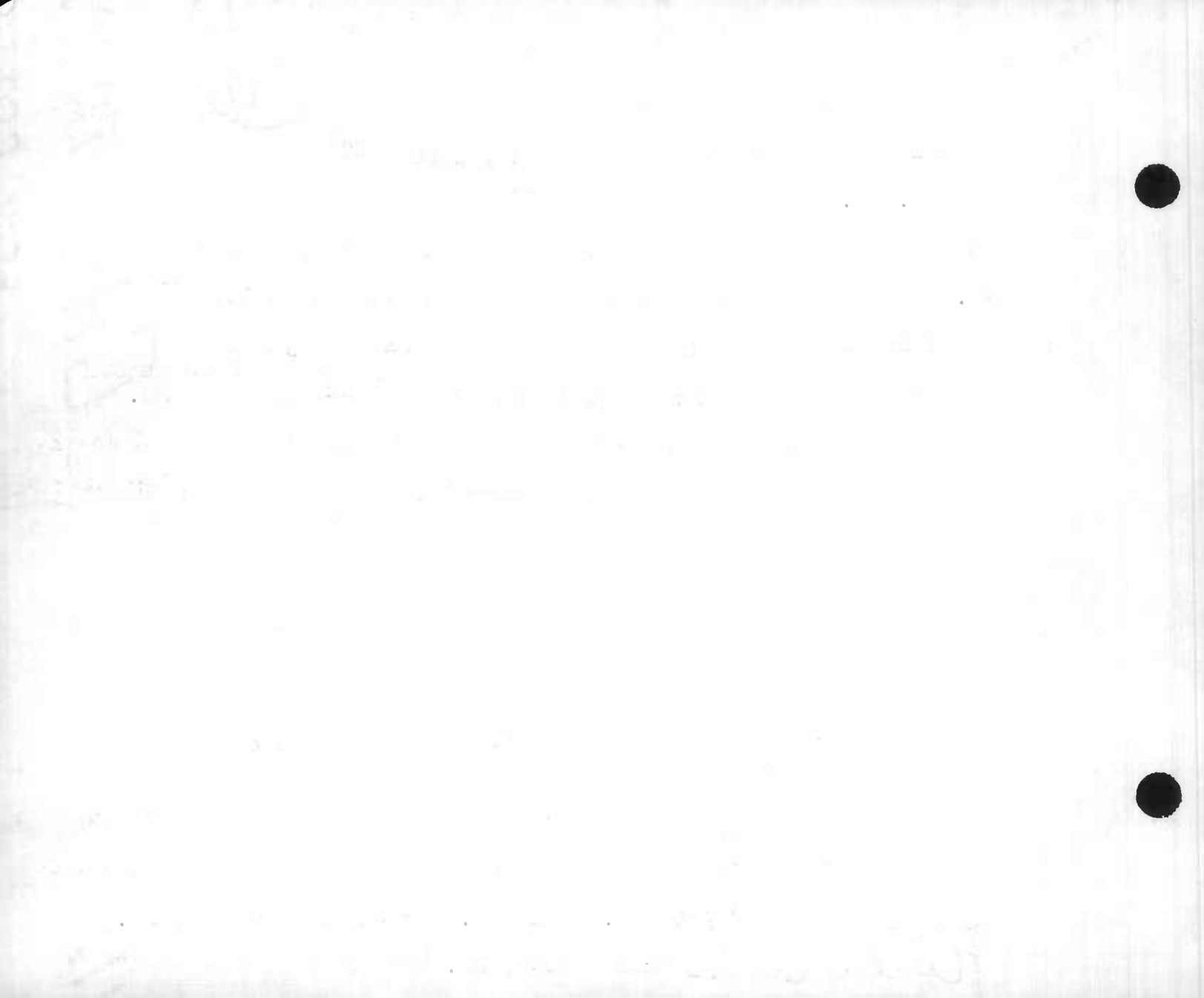
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 4 1 6 / 9 8 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kathleen Northrup Hayes					2a. DATE OF DEATH MONTH DAY YEAR 6/20/84			2b. HOUR 3:50a M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR October 25, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent and Queen Anne's Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Schoolteacher		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Kent Chestertown					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RD # 2 Bx 447 21620		
14. FATHER'S NAME FIRST MIDDLE LAST Tilghman Hubbard					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della Jones				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 221 22 8052		17. INFORMANT RD # 2 ADDRESS Roy Hayes Bx 447 Chestertown Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.I. Bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>									
19a. DATE OF OPERATION <u>✓</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/15/84</u> , 19 <u>84</u> , to <u>6/20</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>6/19</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Schreiber</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>6/20/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SCHREIBER</u>				22e. ADDRESS <u>Medical Building, Chestertown, MD 21620</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6/23/84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>near Chestertown, Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Willis Wells</u>				ADDRESS <u>Chestertown, Md.</u>		25. DATE REC'D. BY REGISTRAR <u>JUN 28 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Davidson-Rendall</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 2 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) LEONARD ALBERT HODGES			2a. DATE OF DEATH MONTH DAY YEAR JUNE 13, 1984		2b. HOUR M	
3 SEX MALE	4 RACE BLACK	5 DATE OF BIRTH MONTH DAY YEAR FEB. 3, 1902	6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8. IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH QUEEN ANNE MD.			
10 CITY OR TOWN OF DEATH CHESTER TOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO IN SUCH FACILITY, GIVE STREET ADDRESS) A7 HOMER F.D.#1		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD		13c. CITY OR TOWN CHESTER TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS CANNON STREET 21670		
14 FATHER'S NAME FIRST MIDDLE LAST UNK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADDIE KENWARD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO YES	17 INFORMANT ADDRESS MRS CORRIE FORKER			
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from Aug 1976, to 5-10 1984, that (I) (we) last saw the deceased alive on 5-10 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE Wayne D. Benjamin		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/14/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WAYNE D. BENJAMIN		22e. ADDRESS CHESTER TOWN, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) B.C.A.I.	23b. DATE 6/18/84	23c. NAME OF CEMETERY OR CREMATORY EMMANUEL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE CHESTER TOWN QUEEN ANNE MD.		
24 FUNERAL DIRECTOR Kenneth Walsh		ADDRESS CHESTER TOWN, MD		25a. DATE REC'D BY REGISTRAR JUN 21 1984		25b. REGISTRAR'S SIGNATURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR 1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 1 6 8 0 0			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST				MONTH DAY YEAR				A M			
Carrie Reafus Hynson				June 11, 1984				11:55 A			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Black		MONTH DAY YEAR 10 31 00				83 YRS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
MD		USA						Kent MD			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Chestertown				The Kent & Queen Anne's Hospital INC				Domestic			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MD				Kent		Chesapeake		YES <input type="checkbox"/> NO <input type="checkbox"/>		Route #1 Box 105 21623	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
James Wilson				Lizette Caldwell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT					
No				219.02.704		Charles Hynson					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CVA - massive											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Advanced ASCVD											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/19/73 to 6/11/84, that (I) (we) lost saw the deceased alive on 6/11/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
CG Bauman				MD				6/11/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
CG BAUMAN				CHESTERTOWN, MD							
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
				6/15/84		Hope-Beeville		CITY OR TOWN COUNTY STATE			
						Hope		GA MD			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS				JUN 21 1984							
Lester H. Deshler				Ester MD							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for visit.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 6 8 0 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN RAY KING			2a. DATE OF DEATH MONTH DAY YEAR June 22, 1984			2b. HOUR P 7 M			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 3, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Hall Nursing center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Building Contractor		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12c. STATE Md.		13a. COUNTY Kent		13b. CITY OR TOWN Worton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RFD # 1 Box 253 21678	
14. FATHER'S NAME FIRST MIDDLE LAST William King				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Pennington					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 05 5024		17. INFORMANT ADDRESS RD # 1 Box # 253 Olive Abigail King Worton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>Organic Brain Syndrome, Arteriosclerotic Cardiovascular Disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 12, 1964</u> , to <u>June 22, 1984</u> , that (I) (we) last saw the deceased alive on <u>June 17, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Susan Ross M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan Ross, M. B.				22e. ADDRESS Chestertown, Md. 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/25/84		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.		
24. FUNERAL DIRECTOR NAME <u>Willis Wells</u>				ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR JUN 29 1984		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

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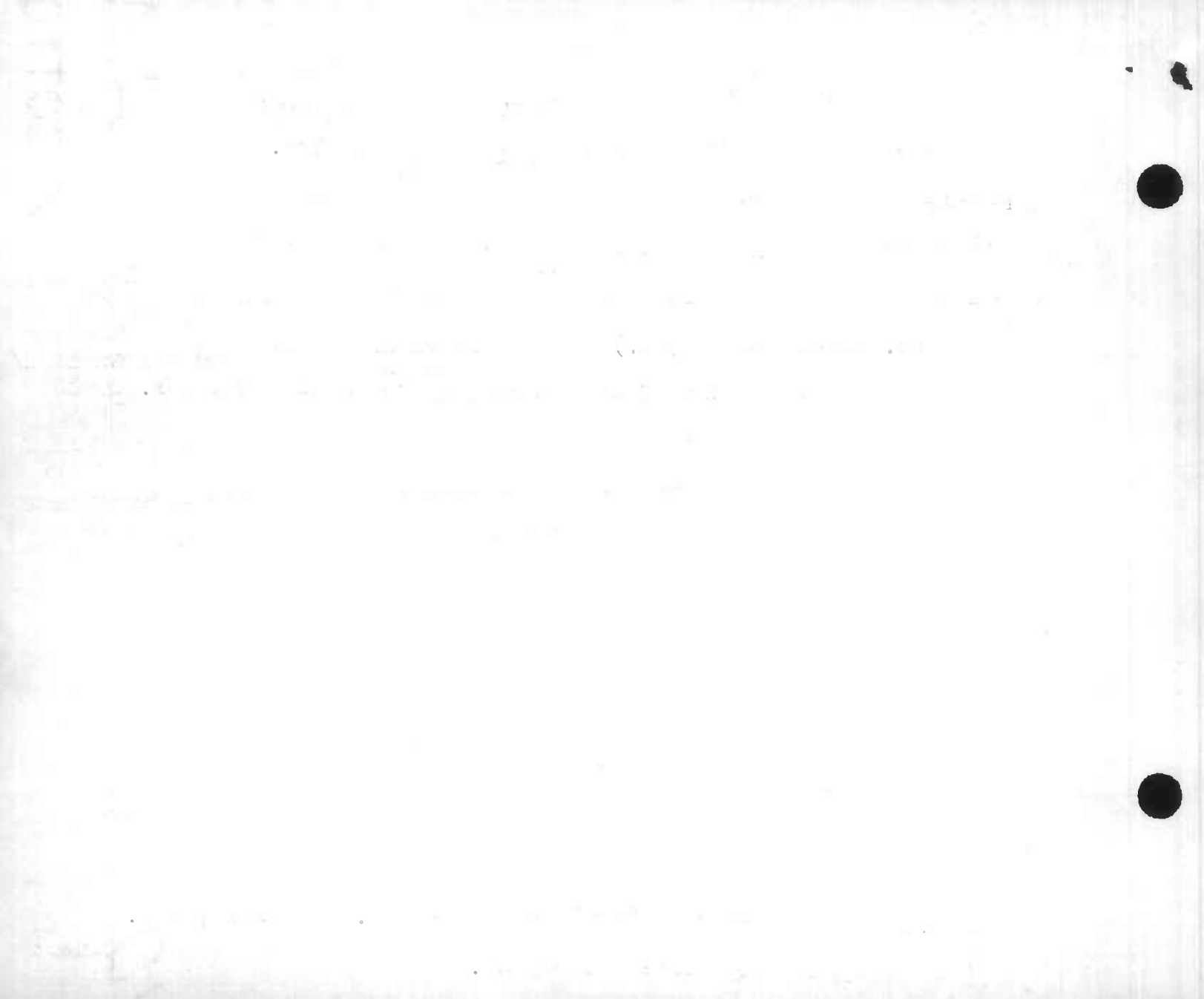
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. (Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 1 6 8 0 2			
1. DECEASED NAME (TYPE OR PRINT) William Bryan Price III				2a. DATE OF DEATH MONTH DAY YEAR June 8, 1984			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 5, 1984		6. AGE (IN YEARS LAST BIRTHDAY) 24 Yrs.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Various	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware		13b. COUNTY Kent		13c. CITY OR TOWN Clayton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Wm. Bryan Price (Jr.)		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patricia Faulkner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218 70 4647	
17. INFORMANT Mother		ADDRESS Rd # 1 Bx 1572		18. CITY OR TOWN Clayton		18. COUNTY Del.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7599 IMMEDIATE CAUSE (a) Respiratory Failure		DUE TO, OR AS A CONSEQUENCE OF (b) Severe Restrictive lung Disease & Cor Pulmonale		DUE TO, OR AS A CONSEQUENCE OF (c) Congenital Acid Maltase Deficiency to Muscular Dystrophy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/7 , 19 84 , to 6/8 , 19 84 , that (I) (we) last saw the deceased alive on 6/7 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Susan K. Ross M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/8/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan K. Ross M.D.		22e. ADDRESS 516 Washington Avenue, Chestertown Md.		23a. NAME OF CEMETERY OR CREMATORY Emmanuel Church Cen.		23b. LOCATION CITY OR TOWN COUNTY STATE Cheswood, Del.	
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23d. DATE 6/10/84		23e. NAME OF FUNERAL DIRECTOR NAME ADDRESS William Wells Chestertown, Md.		23f. DATE REC'D BY REGISTRAR JUN 12 1984	
23g. REGISTRAR'S SIGNATURE Jana Davidson-Randall							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 6 8 0 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mattie NMN Queen			2a. DATE OF DEATH MONTH DAY YEAR 6-4-84		2b. HOUR 9:03 P.M.						
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR Aug. 8, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent					
11. CITY OR TOWN OF DEATH Chestertown		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital, Inc.				13a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) LABOR		13b. KIND OF BUSINESS OR INDUSTRY			
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY QUEEN ANNE		13c. CITY OR TOWN Chesford Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE NEW STREET 21663			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES QUEEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE C. N. K.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) YES		17. INFORMANT ADDRESS MRS. ROCH HANBY ROSELY, MD.							
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD - massive edema 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/1, 1984, to 6/4, 1984, that (I) (we) last saw the deceased alive on 6/4, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C. Gottfried Baumann						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/6/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. GOTTFRIED BAUMANN						22e. ADDRESS CHESTERTOWN, MD. 21620					
23a. BURIAL CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JUNE 9, 1984		23c. NAME OF CEMETERY OR CREMATORY BELTHER CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE CHESFORD HILL QUEEN ANNE MD			
24. FUNERAL DIRECTOR NAME ADDRESS Ruth W. Chastek, Chesford Hill, MD						25a. DATE REC'D. BY REGISTRAR JUN 18 1984			25b. REGISTRAR'S SIGNATURE [Signature]		

BP



FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) EARL LEVI RANSOM				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> 6-14 1984		2b. HOUR M	
3. SEX MALE	4. RACE CAUC	5. DATE OF BIRTH MARCH 2, 1922	6. AGE (In years and birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS 2 DAYS 6	IF UNDER 24 HRS HOURS 6 MIN. 10	2c. DATE PRONOUNCED DEAD Month JUNE Day 17 Year 1984	
7a. BIRTHPLACE (State or foreign country) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH KENT	
10. CITY OR TOWN OF DEATH CHESTERTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 112 QUEEN ST.		12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired.) PAINTER		12b. KIND OF BUSINESS OR INDUSTRY SELF	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY KENT		13c. CITY OR TOWN CHESTERTOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME First Middle Last FLOYD SAMUEL RANSOM				15. MOTHER'S MAIDEN NAME First Middle Last MARY ETTA COX			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16b. SOCIAL SECURITY NO. 219-10-5092		17. INFORMANT 4409 Cooper St. Albany GA 31705			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probable Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. Robert Farr		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 6-22-84			
23a. BURIAL, CREMATION, etc. BURIAL		23b. DATE JUNE 21, 1984		23c. NAME OF CEMETERY OR CREMATORY GALENA CEM.		23d. LOCATION (City or Town) (County) (State) GALENA, KENT, MARYLAND	
24. FUNERAL DIRECTOR FELLOWS F.H. BOX 270 MILLINGTON, MD 21658				25a. REC'D BY REGISTRAR JUL 03 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>	

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-103. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health. Submit to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 4 1 6 3 0 5	
1- FOR STATE REGISTRAR Richard Topfstedt				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard NMN Topfstedt				2a. DATE OF DEATH MONTH DAY YEAR 6/19/84	2b. HOUR 1:25a M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR April 16, 1893	6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.		
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent and Queen Anne's Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer (Standard Oil)	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 10a. STATE 10b. CITY OR TOWN 10c. CITY OR TOWN Md. Kent Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE RFD Chesapeake Landing 21620		
14. FATHER'S NAME FIRST MIDDLE LAST Albert Topfstedt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Known			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 170 01 7671	17. INFORMANT RFD Chesapeake Lnding Geo. U. Howeth Chestertown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 4-20 , 19 79 , to 6/19 , 19 84 , that (I) (we) last saw the deceased alive on 6/19 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.					
22b. SIGNATURE Wayne B Benjamin		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne B Benjamin		22e. ADDRESS Chestertown, Md 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE June 23, 1894	23c. NAME OF CEMETERY OR CREMATORY St. Paul Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE near Chestertown, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS J. Willis Wells Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR JUN 21 1984 25b. REGISTRAR'S SIGNATURE J. Davidson			

MEDICAL CERTIFICATION

(1) The first part of the paper is devoted to a discussion of the general theory of the problem. It is shown that the problem can be reduced to a system of ordinary differential equations. The system is then solved by the method of variation of parameters. The solution is then substituted into the original equations to obtain the final result.

The second part of the paper is devoted to a discussion of the special case in which the parameters are constant. It is shown that the solution can be obtained in closed form. The solution is then substituted into the original equations to obtain the final result.

The third part of the paper is devoted to a discussion of the case in which the parameters are functions of time. It is shown that the solution can be obtained in closed form. The solution is then substituted into the original equations to obtain the final result.

The fourth part of the paper is devoted to a discussion of the case in which the parameters are functions of space. It is shown that the solution can be obtained in closed form. The solution is then substituted into the original equations to obtain the final result.

The fifth part of the paper is devoted to a discussion of the case in which the parameters are functions of both time and space. It is shown that the solution can be obtained in closed form. The solution is then substituted into the original equations to obtain the final result.

The sixth part of the paper is devoted to a discussion of the case in which the parameters are functions of time, space, and a third variable. It is shown that the solution can be obtained in closed form. The solution is then substituted into the original equations to obtain the final result.

The seventh part of the paper is devoted to a discussion of the case in which the parameters are functions of time, space, and a third variable, and a fourth variable. It is shown that the solution can be obtained in closed form. The solution is then substituted into the original equations to obtain the final result.

The eighth part of the paper is devoted to a discussion of the case in which the parameters are functions of time, space, a third variable, and a fourth variable. It is shown that the solution can be obtained in closed form. The solution is then substituted into the original equations to obtain the final result.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. DATE OF DEATH		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. DATE OF DEATH		7b. HOUR	
Anna Elizabeth Walbert		Female		Caucasian		MAY 14 1891		93 YRS.		6-17-84		6:30 M	
7c. BIRTHPLACE (COUNTRY)		7d. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U.S.A.				Kent							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Chestertown		The Kent & Queen Anne's Hospital,		Ins. HOUSEWIFE		HOME							
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE									
Md.		BALCLAY		P.O. Box 53 21607									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
JOHN WESLEY HADAWAY		MARGARET JANE COPPER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT									
No		219-76-2674		1213 MICHAEL CT. VIRGINIA BEACH									
				WESLEY ROYSTON WALBERT									
				VA. 23454									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) C.V.A.													
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardiovascular disease.													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET				CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5-24-84, 196-184 to 1984, that (I) (we) saw the deceased alive on 6-17-84, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
AC. DICK M.D.								6-28-84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
AC. DICK M.D.		CHESTERTOWN MD 21620											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
BURIAL		6/20/84		CHESTER CEMETERY		CHESTERTOWN		COUNTY KENT STATE MD.					
24. FUNERAL DIRECTOR		25. DECEASED'S SIGNATURE				25b. REGISTRAR'S SIGNATURE							
Maurice V. Williams		J. Davidson											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrator, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Ackburn Wallace			2a. DATE OF DEATH MONTH DAY YEAR 6 28 84		2b. HOUR 9:03 AM
3. SEX Male	4. RACE Cal.	5. DATE OF BIRTH MONTH DAY YEAR 3 19 1900		6. AGE [IN YEARS (LAST BIRTHDAY)] 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co. MD.	
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Annes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Ser.		12b. KIND OF BUSINESS OR INDUSTRY Telephone
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Q.A.	13c. CITY OR TOWN Sudlersville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John NMN Wallace			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della Eva Anthony		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 180-05-2381		17. INFORMANT ADDRESS P.O. Box 1030 Lester Wallace Willis, Texas 77378	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) Multiple small strokes DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Nov 19 75 to 6/28 19 84 , that (I) (we) last saw the deceased alive on 6/28 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE C. J. Davidson		DEGREE MD		22c. DATE SIGNED 7/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. J. Davidson		22e. ADDRESS 2100 N. ...			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-2-84		23c. NAME OF CEMETERY OR CREMATORY Millington Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Millington Kent Md.		24. FUNERAL DIRECTOR NAME ADDRESS Edward Fellows & Son Millington, Md.			
25a. DATE REC'D. BY REGISTRAR JUL 3 0 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Rendall			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified of occurrence.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

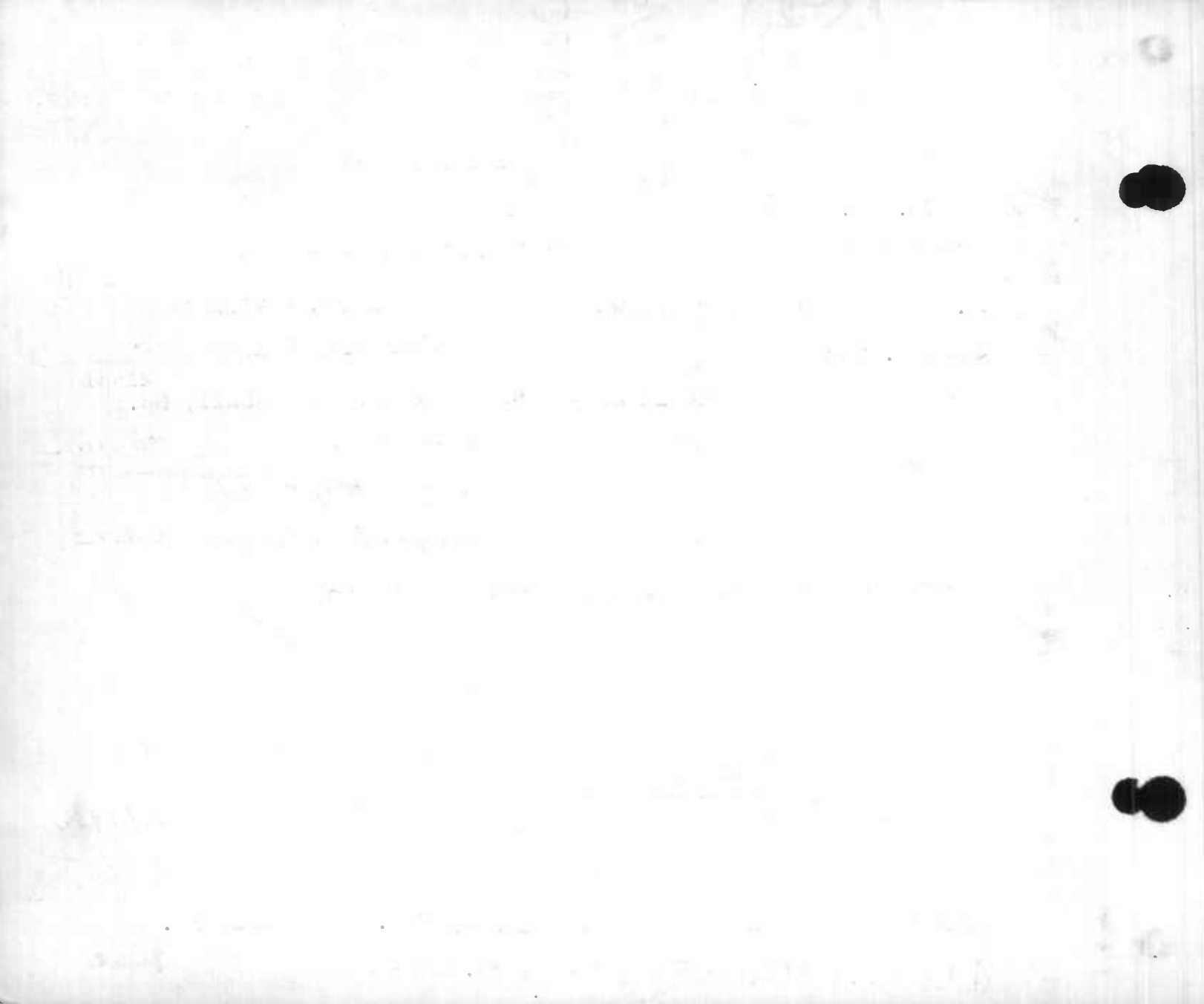
8 4 1 6 8 0 8

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Verma Della Warner			2a. DATE OF DEATH MONTH DAY YEAR June 11, 1984		2b. HOUR 9:40P. M.
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR February 10, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital, Inc.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Morgnec Village 21620
14. FATHER'S NAME FIRST MIDDLE LAST John T. Cox		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vermadella Culley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 12 0183	17. INFORMANT ADDRESS Harvey Brown Rock Hall, Md.		21661	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>(Cardiorespiratory arrest)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Longstanding Coronary artery disease</u> CHAS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <u>Severe Diverticulitis, possible sepsis, pneumonia</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/1/83</u> , 19 <u>80</u> , to <u>6/11</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>6/11</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>C. Gottfried Baumann MD</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>6/11/84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C. Gottfried Baumann MD</u>		22e. ADDRESS <u>Building Chestertown</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/14/84	23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall, Md. MD 21620		
24. FUNERAL DIRECTOR NAME <u>Willis Wells</u>	ADDRESS Chestertown, Md.	25a. DATE REC'D. BY REGISTRAR JUN 14 1984	25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>		

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FOR GRACE MAE WILE										MENTAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 4 6 8 0 9	
1. DECEASED NAME (TYPE OR PRINT) GRACE M AE WILE										2a. DATE KNOWN OF DEATH 6 24 1984										2b. HOUR 1:00 M	
3. SEX Female 4. RACE White										5. DATE OF BIRTH 12-16-1927										6. AGE (IN YEARS) 56 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Kent County										10. CITY OR TOWN OF DEATH Chestertown										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker										12b. KIND OF BUSINESS OR INDUSTRY --										13a. STATE Georgia 13b. COUNTY DeKalb 13c. CITY OR TOWN Clarkston 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 953 Creekdale Dr. 30021	
14. FATHER'S NAME FIRST Jack MIDDLE W. LAST Fortner										15. MOTHER'S MAIDEN NAME FIRST Mattie MIDDLE K LAST Humphery										16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 432-34-5004 17. INFORMANT Clarkston, GA 30021 ADDRESS Mr. Dennis E. Wile 953 Creekdale Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8/29 IMMEDIATE CAUSE (a) Injuries to abdomen from seat belt DUE TO, OR AS A CONSEQUENCE OF with probable internal injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH HEART										21b. TIME OF INJURY 6 24 1984										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Seat belt injury in auto accident	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) U.S. 213										21f. LOCATION Kennedyville CITY OR TOWN Kent Co COUNTY MD STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Robert W. Farr										TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER										DATE SIGNED 6/24/84	
EXAMINER'S NAME (TYPE OR PRINT) ROBERT W. FARR										ADDRESS Chestertown Kent Co Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 6/28/84										23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	
23d. LOCATION Randallstown CITY OR TOWN Baltimore COUNTY MD STATE										24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. NAME 8728 Liberty Rd. Randallstown, MD ADDRESS										25a. DATE REC'D. BY REGISTRAR JUN 26 1984 25b. REGISTRAR'S SIGNATURE R. Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD SIGN PAGE 4 AND 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DDMMYY - 17 (VR AT 15 ME (5)) 15M 7/77

